Example of Plan of Care for Case 3

ANNUAL CERTIFICATION DUE _____

DMA-3000
(REV. 2/93)

CC-010-89

NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE
PERSONAL CARE SERVICES (PCS) PHYSICIAN AUTHORIZATION AND PLAN OF CARE

9/29/03 INITIAL ASSESSMENT (REFERRAL DATE 9/28/03) 11-1-03 REASSESSMENT

Best Care, Inc (PROVIDER AGENCY) | Mayberry, NC (CITY/TOWN) | XXX-XXX-XXXX (PHONE)

PATIENT INFORMATION

1. NAME Frances Feltbetter 2. MEDICAID NO. XXX-client specific
3. ADDRESS 2626 Country Lane, Mayberry, NC
4. PHONE (XXX) XXX-XXXX 5. SEX: ___ MALE ✓ FEMALE 6. DOB 8/20/1923
7. LIVES: ___ ALONE ✓ W/SPOUSE ___ W/ADULT CHILD(REN) ___ W/PARENT(S) ___ W/OTHERS
8. CONTACT PERSON: NAME Floyd Feltbetter RELATIONSHIP husb
ADDRESS 2626 Country Lane PHONE (H) XXX-XXXX (W) XXX-XXXX
9. ATTENDING PHYSICIAN: NAME Arthur Ritts, MD PHONE XXX XXX XXXX
ADDRESS 101 Main Street, Mayberry, NC
DATE OF MOST RECENT EXAMINATION 8/20/03
10. REASON FOR REFERRAL pain; immobility - needs help c bath.
11. DIAGNOSIS (DATE OF ONSET)
Arthritis ~ 20 years; HTN - 10yrs; glaucoma - 8 yrs / cataract c lens implant 1995
12. CURRENT CARE TYPE AND SOURCE
PCS - 30/21.5 a week

EVALUATION

13. MEDICATIONS - NAME/DOSE/FREQUENCY/ROUTE
Celebrex 100mg po in am and hs.
Darvocet N 100mg po q 4h prn severe pain
Ditropan 5mg po BID
HCTZ 25mg po q am
Xylaban drops ii ou @ hs.
Ambien 20mg po @ hs
Ativan 1mg po in am + pm anxiety
SELF-ADMINISTERED? (Y/N) Y IF "N", WHO ASSISTS (NAME/RELATIONSHIP) ___
14. AMBULATION: ___ NO PROBLEMS ___ LIMITED ABILITY ✓ AMBULATORY W/ AID OR DEVICES ___ NON-AMBULATORY
DEVICES/ASSISTANCE NEEDED walker, gait guard - hx of falls
15. NUTRITION: ✓ ORAL ___ PARENTERAL ___ TUBE (TYPE ___)
DIETARY RESTRICTIONS: Low salt
16. RESPIRATION: ✓ NORMAL ___ TRACHEOSTOMY ___ MECHANICAL ___ OXYGEN ___ DYSPNEA
17. SKIN: ✓ NORMAL ___ PRESSURE AREAS ___ DECUBITI ___ OTHER ___
SKIN CARE NEEDS ___
18. BOWEL: ___ NORMAL ___ OCCASIONAL INCONTINENCE (LESS THAN DAILY) ✓ DAILY INCONTINENCE
___ OSTOMY: TYPE ___ SELF-CARE? (Y/N) ___
19. BLADDER: ___ NORMAL ___ OCCASIONAL INCONTINENCE (LESS THAN DAILY) ✓ DAILY INCONTINENCE
___ CATHETER: TYPE ___ SELF-CARE (Y/N) ___
20. ALLERGIES: none
21. ORIENTATION: ___ ORIENTATED ___ SOMETIMES DISORIENTED ___ ALWAYS DISORIENTED
22. MEMORY: ✓ ADEQUATE ___ FORGETFUL-NEEDS REMINDERS ___ SIGNIFICANT LOSS-MUST BE DIRECTED
23. BEHAVIOR: ✓ COOPERATIVE ___ PASSIVE ___ PHYSICALLY ABUSIVE ___ VERBALLY ABUSIVE
___ WANDERS ___ INJURES SELF/OTHERS/PROPERTY ___ NON-RESPONSIVE
___ OTHER anxiety - fearful of falls
24. VISION: ✓ ADEQUATE FOR DAILY ACTIVITIES ___ LIMITED (SEE LARGE OBJECTS) ___ VERY LIMITED (BLIND)
USES: ___ ✓ GLASSES ___ CONTACT LENS
25. HEARING: ✓ ADEQUATE FOR DAILY ACTIVITIES ___ HEAR LOUD SOUNDS/VOICES ___ VERY LIMITED (DEAF)
✓ USES HEARING AID
26. SPEECH: ✓ NORMAL ___ SLURRED ___ WEAK ___ OTHER IMPEDIMENT ___ NONE
27. COMMUNICATION METHOD: ✓ SPEECH ___ GESTURES ___ WRITING ___ NONE
___ ASSISTIVE DEVICE (TYPE ___)
28. OVERALL MEDICAL CONDITION: IS PATIENT MEDICALLY STABLE? (Y/N) Y
29. SPECIAL CARE NEEDS/COMMENTS
client has chronic pain; history of falls

30. UNMET NEEDS: CHECK THE TASKS FOR WHICH THE PATIENT NEEDS ASSISTANCE DUE TO HIS/HER MEDICAL CONDITION AND THE NEED IS EITHER NOT MET OR INADEQUATELY MET. SHOW THE TYPE OF HELP NEEDED AND HOW OFTEN IT IS NEEDED.

Case 3

TYPE HELP NEEDED / HOW OFTEN

PERSONAL CARE

✓	EATING	pre-cut/serve.	daily
✓	GROOMING	hair	daily
✓	DRESSING	assist	daily
✓	BATHING	total bath / transfer to shower chair	daily
✓	USE OF TOILET	transfer/assist	daily 2/3 x
✓	TRANSFER	assist (max); uses walker	daily
✓	AMBULATION	walker, hx of falls- gait guard	daily
✓	MEAL PREPARATION	serve, low salt	daily
	MEDICATION INTAKE	hand/retrieve - husband	daily

INCIDENTAL HOME MANAGEMENT

✓	CLEANING	
✓	LAUNDERING	
✓	ESSENTIAL SHOPPING	
✓	MAKE BED	

31. ARE THERE SOURCES (FAMILY, FRIENDS, PROGRAMS, & AGENCIES) TO MEET ABOVE NEEDS? (Y / N) _____

IF "Y", IDENTIFY SOURCES AND WHICH NEEDS CAN BE MET

husband does shopping, children visit help on Sa, Su

PLAN OF CARE

32 IF THE EVALUATION INDICATES THE PATIENT HAS MEDICALLY-RELATED PERSONAL CARE NEEDS REQUIRING PCS, SHOW THE PLAN FOR PROVIDING CARE. LIST THE DAY(S) SERVICES ARE NEEDED; THE TASKS TO BE PERFORMED ON THOSE DAYS; AND THE TOTAL TIME NEEDED EACH DAY.

DAY OF WEEK	TASKS TO BE ACCOMPLISHED	TIME
M	bath in shower chair, wash hair, dress, assist ↄ toilet, transfer, meal	4.5
T	bath in shower chair, Δ linen, dress, assist ↄ toilet, transfer, meal	4.0
W	bath in shower chair, laundry, dress, assist ↄ toilet, transfer, meal.	4.0
Th	bath in shower chair, dress, assist ↄ toilet, transfer, meal, clean kitchen	4.0
Fr	bed bath, comb hair, transfer, prepare meal, assist to dress	3.0
	assist ↄ toilet	
	each day: make bed, tidy living areas	

33. GOALS: NEED FOR PCS IS EXPECTED TO CHANGE / END (CIRCLE ONE) ON ____/____/____. IF NO CHANGE EXPECTED.

STATE WHY: chronic pain / immobility ↄ arthritis

NURSE ASSESSOR CERTIFICATION

I CERTIFY THAT I HAVE COMPLETED THE ABOVE EVALUATION OF THE PATIENT'S CONDITION.

✓ I FOUND THE PATIENT NEEDS PERSONAL CARE SERVICES DUE TO THE PATIENT'S MEDICAL CONDITION. I HAVE DEVELOPED THE PLAN OF CARE TO MEET THOSE NEEDS.

_____ I FOUND THE PATIENT DOES NOT MEET THE CRITERIA FOR PERSONAL CARE SERVICES.

Renee Real nurse, RN	Renee Real nurse, RN	11-5-03
NAME	SIGNATURE	DATE

PHYSICIAN CERTIFICATION

I CERTIFY THAT THE PATIENT IS UNDER MY CARE AND HAS A MEDICAL DIAGNOSIS WITH ASSOCIATED PHYSICAL / MENTAL LIMITATIONS WARRANTING THE PROVISION OF THE PERSONAL CARE SERVICES IN THE ABOVE PLAN OF CARE.

	11-15-03
SIGNATURE	DATE